Memorandum

To: Members of the Regionalization Workgroup

From: Steve Day

Date: September 20, 2011

Re: Discussion Paper on the Potential Functions of Regions

In its first two meetings, the Regionalization Workgroup has: (a) learned about the Legislative intent associated with SF 525 with regard to the formation and possible functions of regions to manage non-Medicaid MH and IDD services for people in Iowa; (b) heard from three County MH/IDD regional groups in various stages of formation and operations; (c) heard from the Department of Aging regarding the legislatively mandated consolidation of Area Agencies on Aging and the concurrent designation of Aging and Disability Resource Centers [ADRCs]); and (d) reached consensus on recommendations regarding the number and sizes of regions to be formed. In the process of learning about existing regional development initiatives and in formulating criteria for regions, the workgroup has considered a number of core functions to be carried out by these multi-county MH/ID regions.

As discussed by the Workgroup on August 30th, the functions of regions are likely to include:

- Preparation of a Regional Management Plan that has elements similar to the current County Management Plan and Strategic Plan
- Designation of Access Points and the methods for accessing services
- Designation of Targeted Case Management
- Specification of core services and any optional services to be covered
- Specification of providers in the Region's Provider Network
- Process for Grievances and Appeals
- Quality Management and Quality Improvement activities

The purpose of this discussion paper is to facilitate discussion at the September 27th Workgroup session leading to specific and concrete recommendations from the Regionalization Workgroup with regard to which functions will be the responsibility of the regions and how these functions are to be carried out.

TAC envisions that the specification of functions for regions will be the starting point for the development of a performance contract between DHS and the regions. Thus, the specification of functions is expected to include statements about operational capacity and expected standards of performance for each of the proposed functions. Examples of these types of standards or performance expectations are included in the discussion below.

TAC also envisions the functions and responsibilities of the regions as replicating to a certain degree the functions, or "tools" of managed care. The regions will not be managing in a full risk capitated environment, but they will have fixed budgets, and will have to manage funds effectively across a variety of competing consumer populations, service demands and community priorities. So, as with full risk managed care, the regions will have to have the capacity to manage utilization, coordinate care, select providers, process provider claims, assure quality, analyze and forecast financial status, and collect and report accurate data.

1. ***Preparation of a Regional Management Plan (The elements discussed below are also similar to managed care plans)***

The Regional Management Plan is analogous to the County Management/Strategic Plan currently in use in Iowa.[1] The purpose of the management/strategic plan is to spell out in detail <u>what</u> the region intends to do to meet its required performance functions. The plan should also spell out <u>how</u> the region plans to meet its obligations to the citizens of the region, and <u>when</u> certain actions will take place or certain milestones will be reached.

If Iowa DHS were to use a competitive request for proposal (RFP) to select regions, the regional management/strategic plan would constitute a major part of what would be the response to the RFP. Almost all operating entities, from private businesses to housing authorities to Area Agencies on Aging use a management/strategic plan as a basic foundation to their business operations.

As noted above, the regional management/strategic plan functions as part of a performance contract with DHS for the operations of each region. In fact, a region probably could not function or receive funds unless sit had a regional management/strategic plan approved by the state. Equally important, the regional management/strategic plan functions as a compact between the region and the people and communities it serves. The detailed objectives, action steps and indicators of performance included in the regional plan give citizens and communities objective criteria to hold the regional entity accountable to the citizens and communities in the region.

Each responsibility of the regions in Iowa should have a corresponding management plan component. Thus, the outline of the regional management and strategic plans is derived from the roles and responsibilities of regions as determined by DHS and the Legislature. The outline below contains recommended elements for the regional management/strategic plan. The Regionalization Workgroup will discuss these components, and will make recommendations to DHS and the Legislature about which components should be assigned to regions and therefore reflected in the Regional Plan.[2]

[1] Note: several examples of current County Management/Strategic plans are posted on the DHS regionalization Workgroup website. DHS's requirements for County Management/Strategic Plans are also posted on the website.
[2] It is likely that it should be left to the discretion of DHS to define by regulation or program guidance the detailed contents of regional plans below the level of the major component headings. The detail provided is intended to give examples of the types of operational details would likely be included under each component.

A. The Regional Management Plan

- Basic information on the geographic area covered by the region
    - Communities served
    - Socio-demographics of the citizens
    - Locations of major service centers, hospitals, etc.
    - Identification of the central administrative entity for the region (the single point of accountability
    - Description of the governance board of the regional administrative entity
- Description of the roles of consumers and families (and other stakeholders if applicable) in the design, operations and evaluation of regional functions
    - Role/membership of consumer/family or stakeholder advisory groups
- Specification of people to be served
    - IDD (adults and Children)
        - Clinical/level of care criteria for service access
    - MH (Adults and Children)
        - Clinical/level of care criteria for service access
    - Financial eligibility requirements – sliding scale (if applicable)
- Specification of services to be provided
    - Core services
    - Optional services
- Specification of clinical/level of care criteria for accessing each core and optional service for each sub-component of the service population
- Customer relations
    - Information dissemination
    - Information and referral
    - Outreach and engagement
    - Process for consumer and family grievances (not appeals – these are included under service authorizations)
- Designation of access points
    - Locations, contact information
- Description of how services are accessed
    - Roles of access points
    - Roles of the regional administration (what was called the CPC function)
    - Description of the service application process
    - Description of methods to assure consumers informed choice of services and providers
    - Description of how, when, why and by whom clinical assessments are conducted
    - Description of how, when, for whom and by whom a person centered plan is developed
    - Process and criteria for issuing notices of decision (or service authorization process) and continued stay authorization
    - Plan for coordination with Medicaid managed behavioral health care and Medicaid Home and Community Based Services

    - Appeals of service authorizations/decisions
    - Description of how conflict of interest and self-dealing is avoided in the service access, service planning and service authorization processes (note: this is not just an issue for TCM)
- Designation of targeted case management
    - Specify source(s) of TCM for each sub-population
    - Identify specific roles and functions of TCMs with regard to person centered planning, care coordination and service authorization for each sub-population
    - Identify how TCM-like service planning, coordination, linkage and monitoring functions may be carried out by other service modalities (e.g., Assertive Community Treatment teams, community support teams, etc.)
    - Define the responsibilities of TCM with regard to clinical homes and multi system care coordination
    - Define the responsibilities of TCM with regard to care coordination between Medicaid and non-Medicaid services
- Specification of the provider network
    - Name the providers of each core and optional service for each sub-population
    - Specify the methods and criteria for selecting providers for the network
        - Use of state certification/credentialing processes and criteria
        - Use of national accreditation status (Deeming)
        - Use of statewide uniform cost reports and rate setting mechanisms
        - Provider data submission requirements
    - Assurance of provider network sufficiency
        - Choice of provider for core services
        - Cultural linguistic competence
        - Geographic access
    - Methods of provider billing and payment
- Specification of the regional crisis prevention, response and resolution system
    - Crisis planning with consumers, families and providers
    - Early warning systems
    - 24/7/365 call center
    - Mobile services
    - Crisis respite capacity
    - Response to crises in ED's, jails, shelters, etc.
    - Methods for reducing arrests and incarcerations
    - Process for acute psychiatric admission if necessary
    - Specialty crisis capacities for IDD, children and youth, etc.
    - Relationships with first responders, hospital emergency departments, magistrates, advocates, etc.
- Outcome and Performance measurement
    - State domains and indicators: annual performance targets (benchmarks)

    - Regional performance objectives and indicators and benchmarks
    - Use of performance data for management of the quality and effectiveness of the region
- Regional business functions
    - Information technology and data reporting
    - Service authorization and expenditure tracking
    - Provider contracting and performance monitoring
    - Funds accounting and financial forecasting
- Description of inter-organizational relationships and Functions within the Region
    - County officials
    - Justice system
        - Judges/magistrates/advocates
        - Sheriff/police
        - Jail
        - Juvenile justice
        - Probation and parole
    - Education
        - Specific transition planning relationships, points of contact, etc.
    - Housing
    - Employment
    - Substance abuse services
    - Health Care
        - First responders
        - Emergency departments
        - Health centers/FQHCs
    - Description of interagency care coordination process where applicable
- Quality Management/Quality Improvement Plan (summary)[3]
    - Quality issues to be addressed and objectives for improvement
    - Data aggregation[4] and analysis plan related to each issue
    - Process to be used and resources to be committed to each quality objective
    - Time frame for completion

B. The Regional Strategic Plan

- Needs assessment
    - How many of each defined need population (IDD, MH, Children and youth, etc.) are estimated to need the types of services offered under the aegis of the region?
    - Description of special needs for services (e.g., health disparities, cultural or linguistic competence, etc.)

[3] Each region is likely to have a more detailed annual QM/QI plan
[4] Primarily from existing and regularly collected data sources.

- Gaps analysis
    - What are the numeric gaps between the number of people served in each sub group and the estimated need for services for each sub-group?
    - What required or desired services are currently not as accessible or specialized as needed in the region (e.g., there is insufficient IDD supported employment capacity; there is insufficient child crisis response capacity; there are insufficient bi-lingual MH clinicians)
    - What operational functions or systems need improvement to be more efficient and/or to provide more responsive services to constituents (e.g., improved service linkage and consumer choice; improved grievance and appeals process; more accurate data reporting)
- Strategic objectives and action steps
    - What measurable action steps will be taken over a three year period to address identified needs and fill identified gaps in the service system?
    - What steps will be taken to improve the quality and effectiveness of the service delivery system?
    - What steps will be taken to assist providers and their direct service staff to learn new skill and provide better practice services?
- Indicators of progress towards and attainment of strategic plan objectives and action steps
    - Milestones for strategic action steps
    - Indicators of outcomes for consumers/families and communities (what will have actually changed for people and how will it improve their lives?)[5]
    - Specification of incentives/rewards for attainment of or contribution to strategic plan objectives
- Consumer and family Involvement in Plan development
- Other stakeholder involvement on strategic plan development

2. Designation of Access Points and the methods for accessing services

SF 525 lists designation of access points as one key function of the proposed regions. Access points are currently designated by Counties, and are reflected in their existing County Management Plans. Some counties currently identify the County CPC as the single access point, while other counties designate certain providers, hospitals, or first responders as access points.

The functions of access points need to be carefully defined. In essence, an access point is a front door to the services system. By contacting an access point, a consumer or family should be able to (a) make a formal request for services; (b) have their initial (as opposed to ongoing) eligibility to receive certain

[5] These most likely will be drawn from the standard set of outcome and performance measures adopted on a statewide basis

services[6] determined; (c) be referred for initial services if eligible; and (d) receive information and referral if not eligible or qualified for the services managed under the aegis of the region.

If a consumer is accepted into initial services and/or referred to a network provider for assessment and service planning, the access point will have to have the capacity to "enroll" or "register" the person in the system. This latter function assumes that each access point has real time access to the region's client database so they can (a) verify whether or not the individual has already been enrolled and already has a client record; or (b) whether they need to be newly enrolled, which involves collecting and entering sufficient client related information to create viable client record in the system.

Some questions arise about the designation of access points. These include:

- Must an access point be a physical location with people present, or can it be a virtual site accessible only by telephone or e-mail?
- Can an individual person (e.g., a county employee) be designated as an access point, or does each access point have to be a designated organization?
- May a region designate itself and its employees (perhaps located throughout the counties in the region) as the only access points to the system?
- Must an access point have on-line or web-based access to the region's client enrollment system, as opposed to phone or FAX access?
- May a provider that delivers services within the region's network also be an access point? If so, what steps will the region take to assure that no conflict of interest or self-dealing occurs?
- Conversely, should regions be required or encouraged designate major providers in their networks to be access points to assure maximum access and convenience for consumers and families?
- Each region must incorporate at least one inpatient psychiatric facility and one CMHC or FQHC. Should or must each of these be designated as access points?
- If there are independent TCM providers, can or should these also be access points?
- Will all the previously-designated access points under the County-based system be "grandfathered" as access points in the regional system?

From the perspective of state policy and standards, and also from the perspective of consumers and families, there are several factors to be considered with regard to the designation by regions of access points. These include:

[6] Note: eligibility for home and community based waiver services and other high end services will depend on qualified clinical assessments, development of person centered plans, and approval by the payer source (State or CPC in most cases). Initial eligibility for certain services means eligibility to move part way into the system to receive an assessment, perhaps a person centered plan, and perhaps some services and supports pending access to higher end services. Some services (e.g., crisis response; fewer than 10 outpatient encounters, etc.) may require no further authorization than referral from the designated access point.

- Ease of access on the part of consumers and their families. Each region must demonstrate how their designated access points will assure ease of access. Criteria for ease of access typically include:
    - Geographic proximity – close to one's home community
    - Accessible by public transportation
    - Cultural and linguistic competence
    - "Normal" way for people to seek information about and access to service (e.g., through the hospital emergency department; through first responders; through well known county offices; etc.)
    - 24/7/365 capacity (not all access points, but at least one for each region)
- Consistency among all access points. The region must describe how it will assure that citizens experience the same degree of responsiveness and ease of access wherever they present in the system
- Integration of access point functions with other elements of service access and care coordination – ease of movement as appropriate into clinical assessment, service plan development, TCM, multi-agency service plans, etc.
- Accountability for access point performance: the region should describe performance indicators for access points and describe its plan to monitor and assure accountability for access point performance.

3. Designation of Targeted Case Management

SF 525 specifies that regions will designate targeted case management. TAC assumes that "designation" means that each region will identify and designate each source of TCM for each consumer sub-population within the region. TAC also assumes that DHS/IME will specify: (a) which consumers must have TCM as a condition of receiving services (e.g., Home and Community Based Service [HCBS] waiver participants, PMIC referred youth, etc.); and (b) who may receive TCM because they can benefit from having a person centered plan and on-going care coordination. DHS/IME also defines Medicaid provider certification requirements to be met by any entity to be designated to deliver and bill for TCM. Regions will then designate in the Regional Management Plan the method(s) by which the delivery of TCM to the defined populations by qualified entities will be assured.

There are some service modalities that incorporate TCM-like functions (assessment, service planning, service linkage, service monitoring) into the direct service modality itself. Examples include Wraparound services for youth and assertive community treatment (ACT) for adults. Self direction of services is expanding as well, and this has consequences for TCM, particularly for those exercising self-direction in the context of HCBS.

TCM is currently provided through a variety of sources, including counties themselves, DHS, and contracted providers. And, based on anecdotal reports, there is variation among counties and among TCM providers in the philosophy, delivery and accountability of TCM approaches.

Although SF 525 anticipates discretion on the part of regions with regard to by whom TCM will be provided, there is also clear Legislative intent that there be state-wide consistency of TCM for all consumers and families. Thus, whatever mechanisms/outlets regions designate to provide TCM, there must be assurances that TCM will be provided in a consistent manner and that regions will monitor and assure the quality and effectiveness of their designated TCM providers.[7]

Issues and standards related to the designation of TCM by regions include:

- Will or may current TCM providers be "grandfathered" as designated TCM providers?
- Could a region have only one designated TCM provider, or does each region need to assure that consumers have a choice of TCM providers?
- Could consumers access DHS case management irrespective of Regional designation? If so, what force would that consumer's person centered plan have with regard to the region's service authorizations?
- People needing TCM vary considerably in their clinical presentation and needs and choices. Each region must show how designated TCM providers have the requisite clinical skills and experience for each of the populations to be served (e.g., people with IDD; adults with mental illness; children and youth with emotional disturbance and/or IDD or behavioral issues requiring out of home placement).
- Some consumers and families will elect self direction of services. Each region will have to have a plan (consistent with statewide program guidance) for the interrelationship between TCM and self-direction.
- One goal for MH and IDD services in Iowa is for every long term, high need consumer to have an identified clinical home. Regions should describe in their TCM plans how accessing a clinical home will be accomplished and define how the TCM function will interact with the person's clinical home.
- As with access points, the regions will have to have a plan for holding designated TCM providers accountable for meeting state standards. Thus, each region's TCM plan will have to identify indicators of performance and a TCM quality monitoring process, and describe how these will be used to assure accountability and consistency of TCM operations within the region.

[7] TAC assumes that all TCM providers, including Counties and DHS, will have to abide by the same standards, meet the same performance criteria, and produce the same data. However, the methods by which Regions assure accountability to standards will vary based on which entit(ies) are designated to deliver TCM.

4. Specification of core services and any optional services to be covered[8]

Based (in part) on recommendations from the IDD, Mental Health, and Children's work groups, DHS and the Legislature will adopt a set of core services to be included in each Region's management plan. Regions will have to assure equity and ease of access to these core services for eligible consumers within their regions, consistent with available resources. TAC assumes the regions will have no discretion about what core services are included in the plan, but only will have an obligation to show in the plan how these core services will be implemented and accessed. If a region does not have providers with the necessary capacity to deliver all core services in accordance with state standards, then TAC assumes that region's strategic plan will have to identify the gap(s) and identify the action steps that will be taken to assure appropriate access to core services in the near future.

Not all eligible consumers will be eligible for all core services. Thus, the Region will have to define in the management plan which core services are for each sub-population (IDD, MH, children and youth, dual diagnosis, etc.). There will also be more specific entry or access criteria for certain core services (e.g., PMIC's, HCBS, ACT, etc.), and these must also be detailed in the Regional plan.

Equally important, there may not be sufficient resources at any given time to assure access to all core services on the part of every eligible recipient. Thus, the regions will have to have transparent and equitable policies and procedures for establishing waiting lists or other mechanisms for (a) establishing a queue for people to gain access to services when resources become available; and (b) maintaining contact and perhaps some services and supports for people while they are waiting for services. In the case of HCBS, where there is a statewide waiting list, each region will still need a protocol for how they will maintain contact with and support of consumers and their families in their regions while they are waiting for HCBS services.

Finally, it must be assumed that not all regions will have an adequate supply of all the defined core services for each component of the target population. As a corollary, not all regions will inherit county spending patterns and provider contracts that reflect core services. In fact, there may be some current services being funded in the system today that would not meet the criteria for either a core services or an evidence based or promising practice. TAC assumes there will need to be some transition time frame within which Regions will be converting from their current service systems into systems that reflect core services and best practices.

If resources are available, it may be possible for regions to include optional services in their regional management plans. This raises questions about how much discretion regions should have with local funds, particularly if there are remaining gaps in defined core services. There is also a question about whether a region should be allowed to expend public funds of whatever source on non-evidence based practices. (Note: TAC would recommend that in some cases such expenditures on experimental but

[8] Note: there will be a separate issue developed on crisis services for consideration by each of the other work groups. Thus, crisis services are not specifically discussed here.

promising services, and/or on service infrastructure that can increase service quality and effectiveness, is appropriate).

5. Specification of Providers in the Region's Provider Network

Regions will be expected to identify providers of each core and optional service for each of the defined sub-populations. This is usually displayed in the form of a provider network matrix, as is commonly used in current County Management Plans in Iowa.

TAC assumes that regions will not have to accept "any willing provider" and thus will have discretion to exercise judgment in the selection of providers for their networks. However, this discretion is expected to be limited, in that most providers will de facto have to meet some form of state licensure or certification requirements, and some may also have or be required to attain national accreditation.

Some jurisdictions use competitive RFPs to select network providers. Other jurisdictions selectively admit providers to networks if they agree to (a) abide with a standard contract or network agreement; and (b) agree to accept the rate and method of reimbursement provided by the jurisdiction.

There are several issues to be considered related to regional provider networks:

- Should existing providers in the IDD and MH systems be "grandfathered" into the regional networks?
- What happens to current providers of services that are not defined as core or optional services?
- What criteria should be used to define network sufficiency?
    - Choice of provider for each service for each population
    - Demonstrated skill and experience with IDD, MH, children and youth and people with dual or multiple disabilities as applicable
    - Ease of geographic access (or mobile services or other accommodations if geographic access and transportation is difficult)
    - Cultural and linguistic competence
- Should regions be required to adopt state uniform cost reports and rates?
- Should regions be required to "deem" as qualified any provider that has been certified or licensed by the state or who has national accreditation?
- Should a provider admitted to one region's network be deemed to qualify to be in all other region's networks?
- How much time should be allowed for regions to meet network sufficiency standards?

6. Process for Grievances and Appeals

Each region will have to implement processes and protocols for grievances and appeals. Grievances are typically generated by consumers and families, and may address a variety of issues, from provider

performance to service access to receiving sufficient for informed decision-making. Appeals are made by consumers, families and/or providers, and are based on specific decisions of the region (or its agents) with regard to authorization of service access or continued stay.

Processes for resolving grievances are typically informal, and include information collection, meeting with the parties, and attempts to remediate the situation. Processes for appeals are more formal, and involve accessing a higher level of clinical authority to review the initial service authorization decision. Consumers and providers also have the right to appeal to the state if they are not satisfied with the decision at the regional level.

Regions are likely to have discretion within state guidelines with regard to how the grievance process is designed. State standards and criteria for grievances usually include:

- Clear and widespread communication to consumers and families about their right to file grievances and the process for doing so;
- Active involvement of consumers and families in hearing and resolving grievances;
- Resolution of grievances within defined time frames (usually less than a month from the time of filing the grievance to successful resolution); and
- Transparent reporting of grievances as part of the QM/QI process.

Because appeals are formal, involve the allocation of service resources, and can go to the state for second-level appeals, it is likely the DHS will define a standardized process for regions to implement. That process will include definition of clinical expertise necessary to hear appeals; strict time frames for action at every stage of the appeal; requirements for service delivery or continuance pending the outcome of the appeal; and requirement for information to be provided to consumers and providers about their right to appeal regional service authorization opinions.

7. Quality Management and Quality Improvement (QM/QI) activities

TAC assumes that each region will be required to have a quality management/quality improvement plan that meets DHS requirements and guidance. The plan will also need to address and be consistent with the Centers for Medicare and Medicaid (CMS) quality framework. Providers in the regional networks will likely be required as part of their network agreement to participate with their respective regions in quality management and quality assurance activities.

Conceptually, the QM/QI plan should align with the region's management and strategic plans. That is, the QM/QI plan should focus on issues of primary importance to the region in (a) meeting state standards and requirements related to the functions of regions; and (b) accomplishing strategic objectives related to expanding and improving best practice service access, delivery and effectiveness. The QM/QI plan will identify priority issues related to the outcomes of care, focusing on areas in which consumer outcomes (as defined by state indicators) are not being met satisfactorily. The QM/QI plan will also focus on the process of care, addressing areas in which the process of service access,

assessment, service planning, care coordination, service linkage and follow up could be more effective and responsive.

There are several standards or criteria that could be adopted by DHS for regional QM/QI plans. These include:

- Extensive and meaningful participation of consumers and families in QM/QI planning, issue identification and activities;
- Effective use of data related to consumer outcomes and system performance to identify QM/QI priority issues and to track progress in QM/QI initiatives;
- Effective use of information from the grievance and appeals processes for QM/QI planning and activities;
- Effective involvement of network providers in QM/QI planning, issue identification and activities; and
- Regular posting and dissemination of QM/QI information for stakeholders in the region.

Summary: Big Questions to be addressed by the Regionalization Work Group

1. What is the correct list of functions to be included within the defined scope of responsibility and accountability for regions?

Function	Yes	No	Comments
Regional Planning			
Designation of Access Points			
Designation of TCM			
Plan for Core Services			
Plan for Optional Services			
Assure effective crisis prevention, response and resolution			
Provider network formation and management			
Provider rate setting			
Provider certification			
Grievances and Appeals			
Quality Management/Quality Improvement			
Payment of providers			
Funds accounting			
Financial forecasting			
Data collection and reporting			
Interagency collaboration			
Grievances and appeals			

2. What should be the primary domains for performance measurement and accountability for regions?

Performance Domain	Yes	No	Comments
Attainment of consumer and family outcomes			
Attainment of system performance outcomes			
Attainment of defined quality standards			
Ease of access to core services			
Effective and consistent operations of TCM			
Provider network sufficiency			
Successful crisis prevention and diversion			
Evidence of continuous quality improvement of all regional functions, including provider quality and effectiveness and workforce development			
Timely and accurate payment of providers			
Accurate funds management			
Compliance with applicable state regulations and the performance contract between the state and the regions			
Timely and effective resolution of grievances and appeals			

3. In what functional areas of responsibility and responsibility should Regions have discretion?

Function	Discretion within state standards	No Discretion	Comments
Regional Planning			
Designation of Access Points			
Designation of TCM			
Plan for Core Services			
Plan for Optional Services			
Assure effective crisis prevention, response and resolution			
Provider network formation and management			
Provider rate setting			
Provider certification			
Grievances and Appeals			
Quality Management/Quality Improvement			
Payment of providers			
Funds accounting			
Financial forecasting			
Data collection and reporting			
Interagency collaboration			
Grievances and appeals			